



S.C. Department of Labor, Licensing and Regulation
Board of Medical Examiners
110 Centerview Drive
Post Office Box 11289
Columbia, SC 29211
(803) 896-4500



**APPLICATION FOR A LIMITED LICENSE TO PRACTICE AS A RESPIRATORY
CARE PRACTITIONER**

IMPORTANT: Read the enclosed requirements carefully before completing application. Appropriate fee must accompany application; **application fee is non-refundable.** *The application form itself is a public document obtainable under the Freedom of Information Act.*

I hereby make application for a license to practice as a respiratory care practitioner in the State of South Carolina and submit the following statements of facts with the required supporting documents:

(Please type or print clearly)

Applicant's Name: _____
Last First Middle

Home Address: _____

City State Zip

Home Phone: () _____

Email Address: _____

S.C. Medical Director: _____
(If not known at this time, mark "unknown at this time")

Place of Employment in South Carolina: _____
(If not known at this time, mark "unknown at this time")

Street

City State Zip

Business Phone () _____

*Social Security Number: _____

*The SSN is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state medical boards to report to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Date Bank (NPDB), among other things.
(Revised 7/10/12)

CONTROL # _____

CHECK # _____

AMOUNT \$ _____

I. PERSONAL DATA

Answer Yes or No

1. Has your Respiratory Care Practitioner certificate/license ever been revoked, suspended, reprimanded, restricted or placed on probation by any licensing board or any other entity? _____
2. Have you ever had an application to practice as a Respiratory Care Practitioner denied or refused by another licensing board or entity? _____
3. Have you ever had hospital privileges denied, revoked, suspended or restricted in any way? _____
4. Have you ever resigned from any hospital, institute or health care facility in lieu of disciplinary action? _____
5. Are you currently under any investigation or the subject of pending disciplinary action by any licensing board or other entity? _____
6. Is your Respiratory Care Practitioner's certificate/license currently restricted in any way by any medical licensing board, health care facility or other entity? _____
7. Currently or within the last ten years, have you been treated for any physical, mental, or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice as a Respiratory Care Practitioner? _____
8. Has your ability to practice as a Respiratory Care Practitioner ever been impaired by any physical or mental illness or by the use of alcohol or drugs? _____
9. Currently or within the last ten years, have you developed any disease or conditions, physical, mental or emotional, (e.g. bipolar disorder, schizophrenia, paranoia or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice as a Respiratory Care Practitioner? _____
10. Have you ever discontinued practicing as a Respiratory Care Practitioner for any reason for one month or more? _____
11. Have you ever been arrested, indicted, or convicted, pled guilty, or pled nolo contendere for violation of any federal, state or local law (other than a minor traffic violation)? _____
12. Have you ever been known by any other name or surname? _____
13. Have you ever voluntarily surrendered a Respiratory Care Practitioner's certificate/license? _____
14. Have you ever been discharged involuntarily from employment? If so, give full details. _____

NOTE: If you answered "yes" to any of the above questions (1-14), you must attach a full written explanation pertaining to that particular question.

II. EDUCATION

Attach copies of diplomas, degrees and certificates of training.

School attended Name and Address	Dates Attended From (Mo./Yr.) to (Mo./Yr.)	Diploma or Degree Received
High School:		
College:		
Respiratory Therapy Training:		
Graduate School:		

AFFIDAVIT OF RESPIRATORY CARE PROGRAM DIRECTOR

(Complete only if presently a student)

This is to verify that _____ is a student in the
(Name of Applicant)

Respiratory Care Program at _____
(Name of School)

which is a program approved by the Joint Review Committee for Respiratory Care Education and should graduate on

(Date of Expected Graduation) Respiratory Care Program Director

Sworn to me and subscribed before me this _____

Day of _____, _____

(L.S.) for : _____
Signature of Notary Public

My Commission Expires: _____

II. EDUCATION
(continued)

1. When do you expect to take the entry level National Board for Respiratory Care, Inc., examination?

Date: _____

NOTE: If you receive a Limited License from this Board prior to graduation, proof of graduation (diploma, certificate of completion or transcripts) must be received by the Board office within 30 days of graduation or your Limited License will be deemed void and application fee will be forfeited.

III. EMPLOYMENT HISTORY

In chronological order (most recent first), list all employment relevant to training and/or work experience in respiratory therapy since graduating from your respiratory care program.

Place of Employment (Name of Company, City and State)	Dates of Employment	Title and Job Description

(Attach additional sheet of paper is needed)

IV. REFERENCES

(These persons should not be related to you by blood or marriage.) The references listed must be more than a casual acquaintance and of a substantial duration but need not be a respiratory care practitioner.

Please have statements from your references as to your moral character and fitness forwarded to the Board office on the enclosed Board form.

Name	Street or Mailing Address	Occupation
1.		
2.		
3.		

V. AFFIDAVIT

I, _____ being duly sworn, depose and say that I am the person described and identified, that I am of good moral character and that I am the person named in the documents presented in support of this application. By filing this application, I hereby authorize and consent to an investigation of my fitness and qualifications to practice as a Respiratory Care Practitioner in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, and federal) to release to this licensing Board any information, files or records requested by the Board for its evaluation of my professional, ethical and other qualifications for licensure in South Carolina. I hereby release, discharge and exonerate the State Board of Medical Examiners of South Carolina, its agent or representative and any person or organization furnishing information from any and all liability of every nature and kind arising out of the furnishing of documents, records or other information, or arising from the investigation made by the State Board of Medical Examiners of South Carolina.

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such act shall constitute the cause for denial or revocation of my license to practice as a Respiratory Care Practitioner in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address.

I hereby authorize the Board of Medical Examiners of South Carolina to utilize my Social Security Number in making necessary reports to the Federation of State Medical Boards' Physician Data Center for compilation of information about applicants and licensees in order to coordinate licensure and disciplinary activities between the individual States' licensing boards, and to federal and state entities, as required by law.

Applicant's Signature: _____ Date: _____

Subscribed and sworn to before me this _____ day of _____, _____.

Notary Public Signature: _____ (L.S.) for: _____

My Commission Expires: _____

AFFIDAVIT OF ELIGIBILITY

Pursuant to section 8-29-10 of the South Carolina Code of Laws (1976 as amended), the Department of Labor, Licensing and Regulation must verify the lawful U.S. presence of any person who applies for a South Carolina license. Please complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

I, (please print your full name) _____, swear or affirm under penalty of perjury under the laws of the State of South Carolina that (check 1, 2 or 3 below):

1. ____ I am a United States citizen or legal permanent resident eighteen years of age or older; or
2. ____ I am not a US citizen but am lawfully present in the US as evidenced by one of the following
 - a. ____ I am a qualified alien as defined in 8 U.S.C. sec 1641, eighteen years of age or older.
 - b. ____ I am a nonimmigrant under the "Immigration and Nationality Act," Federal Public Law 82-414 as amended, eighteen years of age or older.
3. ____ I am not physically present in the US under 8 U.S.C. sec 1621 (c) (2) (c) or employed in the US pursuant to 8 U.S.C. 1621 (c) (2) (a) (check either a or b below):
 - a. ____ I am a US citizen, not physically present or employed in the United States.
 - b. ____ I am a Foreign National, not physically present or employed in the United States.

If you selected either 3.a. or 3.b., you do not need to complete Section B. Skip to Section C.

Section B: Secure and Verifiable Document. This section must be completed if you checked number 1 or 2 in Section A.

1. Please check one of the following acceptable secure and verifiable documents. Complete documentation must be provided.

- ☐ Any valid South Carolina Driver's License, South Carolina Driver's Permit or South Carolina Identification Card? Number _____; Date of Expiration: _____
- ☐ Any valid out-of-state issued photo Driver's License or photo identification card, photo driver's permit? State: _____; Number _____; Date of Expiration: _____.
- ☐ Permanent Resident Card; Alien Number _____; Card Number _____; Date of Expiration: _____.
- ☐ Employment Authorization Card; Alien Number _____; Card Number _____; Date of Expiration: _____
- ☐ Certificate of Naturalization with intact photo.
- ☐ Certificate of (US) Citizenship with intact photo.
- ☐ Other: (Name of verifiable document) _____

2. Enter the state or the federal agency name where this secure and verifiable document was issued.

(If issued by a state agency, include both the state and agency name.)

3. Please provide your social security number: _____/_____/_____

Section C: Attestation.

- I understand that this sworn statement is required by law because I have applied for or seek reinstatement of a professional or commercial license as provided for in 8 U.S.C. §1621. I understand that state law requires me to provide proof that I am lawfully present in the United States.
- I understand that in accordance with section 8-29-10 of the South Code, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a felony.
- I am the person identified above, and the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.

Signature

Date

Please print your name as shown on your secure and verifiable document.

Professional License Type: _____

License Number (if already licensed): _____

The South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

06/28/12 Affidavit of Eligibility

PHOTOGRAPH

THIS SPACE FOR OFFICE USE ONLY

APPLICATION FOR LIMITED LICENSE
RESPIRATORY CARE PRACTITIONER
LICENSURE

Issued by the
South Carolina Department of Labor, Licensing
and Regulations
Board of Medical Examiners
110 Centerview Drive
Post Office Box 11289
Columbia, South Carolina 29211
(803) 896-4500

NOTE: A recent portrait type
photograph must be pasted here.
Photograph must be passport size or
snap shot.

Approved by Board /Committee Member:

Board/Committee Member Signature

Date Approved

GENERAL INFORMATION

Date of Birth: _____

Place of Birth: _____

Sex: _____ Race: _____

Height: _____ Weight: _____

<p align="center">REQUIREMENTS FOR A LIMITED LICENSE TO PRACTICE AS A RESPIRATORY CARE PRACTITIONER</p>
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I. GENERAL INFORMATION

Limited license applies to an applicant who presents written documentation, verified by oath, that he/she is a student or graduate of a Joint Review Committee for Respiratory Care Education approved respiratory care program. If a student, he/she must be scheduled to graduate from this program within 45 days of the date of application. A limited license issued under this section is valid for a period of six months. A limited license may be renewed only once. Renewal fee is \$40.

II. LIMITATIONS

Practitioners holding a limited license may practice under the direct supervision of a licensed Respiratory Care Practitioner.

III. REQUIREMENTS

In order to qualify for a limited license, the applicant must file a written application on forms provided by the Board and must show that he/she meets the following requirements:

- (a) good moral character;
- (b) verification that applicant is a student or a graduate of a Joint review Committee for Respiratory Care education approved program. If a student, expected graduation within 45 days;
- (c) submission of completed application form;
- (d) application fee submitted (\$40) and;
- (e) all supporting documents and/or information required by the application form received.

IV. FEES (Application fee is non-refundable)

Application fee for a six month limited license is forty (\$40). Renewal of limited license is forty (\$40.)

V. APPLICATION FORM

The application form itself is self-explanatory. It sets forth the required supporting documents and/or information that must be submitted with your application. The Board will not consider an applicant for a limited license until a completed application along with appropriate fee is submitted.

VI. PROCESSING TIME

Applications that have all information with no identifiable problems will be expeditiously processed. Incomplete applications or problematic applications will require additional processing time.

- VII.** If you do not know where you will be working in South Carolina and/or who the medical director is, please mark “unknown at this time in that space. Please remember, before you can begin working in South Carolina, you must notify the Board in writing of where you will be working, in South Carolina, and who the medical director will be.

NOTE: If you receive a limited license from this Board prior to graduation, proof of graduation (diploma, certificate of completion, or transcript) must be received by the Board office within 30 days of graduation or limited license will be deemed void and application fee will be forfeited.

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(803) 896-4515 fax

REFERENCE FOR RESPIRATORY CARE PRACTITIONER APPLICANT

- Make copies of this form and provide to each reference
- Type or print clearly
- Individuals giving a reference should know you in a professional capacity. They cannot be related by blood or marriage

Applicant's Name: _____

Dates of Association: _____

Relation to Applicant: _____

Describe the applicant's moral character and fitness (attach a separate sheet of paper if necessary)

Moral Character: _____

Professional Competence: _____

Interpersonal Relations with Others: _____

Name (Print) _____

Address _____
Street City State Zip

Telephone Number (during business hours) _____

Signature _____ Date _____